UNDERGRADUATE MEDICAL AND DENTAL EDUCATION

Second Report of the Steering Group

June 1990

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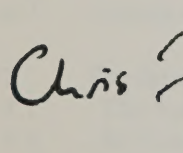
FOREWORD

In this its Second Report, the Steering Group on Undergraduate Medical and Dental Education has built on the work which it undertook before the publication of the NHS White Paper "Working for Patients", and which was summarised in an Interim Report issued in June 1989. The Group then turned its attention to the implications of the White Paper for medical and dental education. The results of its work are distilled in the 33 recommendations at paragraph 8.2.

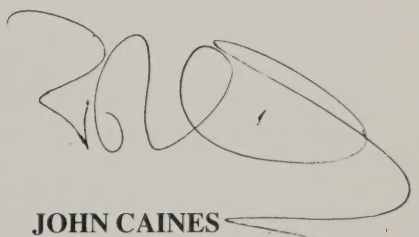
The Group was conscious that it needed to offer recommendations which would sustain and enhance undergraduate medical and dental education in the new NHS. In part, the Group has sought to achieve this by ensuring that the management arrangements between universities and the NHS are adequate for the new tasks they will have to face. The Group has also recommended clearer and more systematic arrangements for the distribution of the Service Increment for Teaching (SIFT), while at the same time allowing hospitals which provide such support not to be disadvantaged in pricing their services.

The Second Report has been endorsed both by a conference of the major bodies responsible for undergraduate medical and dental education and by the Secretaries of State for Health, for Education and Science, and for Scotland. All concerned have also agreed that the work of the Group should continue with its remit extended to include consideration of the arrangements for clinical research with service implications (including health services research). The Group will also have an important role in monitoring the effect of the NHS reforms on undergraduate medical and dental education. It will need to be closely involved in the review of SIFT which it is intended should be complete by 1992. But the Group will continue to make its recommendations as it proceeds. Its future will again be considered in about two year's time; it will not necessarily become a permanent feature.

The Group has been assisted by two Task Groups; their contribution has been invaluable. All those involved, whether drawn from the universities or the NHS, have vividly illustrated what can be achieved by purposeful collaboration. But, as the Second Report says, liaison and consultation are not enough for effective collaboration. Both parties engaged in undergraduate medical and dental education and research must recognise their unity of purpose, and combine in a joint enterprise to achieve it.



SIR CHRISTOPHER FRANCE
Permanent Secretary
Department of Health



JOHN CAINES
Permanent Secretary
Department of Education
and Science

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1. SYNOPSIS:

1.1 The Secretary of State for Health asked the Steering Group on Undergraduate Medical and Dental Education for advice on the management of the interface between universities and the NHS, in the light of the proposals for NHS reform contained in the White Paper "Working for Patients" (Cm 555). Our advice is contained in this report.

1.2 We particularly wish to emphasise the importance of ensuring close and effective working relationships between universities and the NHS. We believe that effective collaboration between universities and all levels and parts of the NHS is essential to the maintenance of the high standards of medical and dental education which are universally desired.

1.3 We have concluded that a wide variety of organisational arrangements is compatible with effective collaboration between universities with medical and dental schools and the NHS. Existing local variations in structure would tend to develop further as the role and functions of health authorities change and NHS Trusts become established. We have not been prescriptive; we have proposed that all relationships between universities and the NHS must adhere to ten key principles, set out in paragraph 4.3 of this report. The essence of these principles is that universities and the NHS have a shared responsibility for undergraduate medical and dental education. Since effective clinical teaching depends on a partnership between clinical academic staff and NHS staff, it is important that universities and the NHS work closely in the planning and management of medical and dental education and research.

1.4 Regional Health Authorities and universities will have a continuing and enhanced need for regular and effective cooperation. In addition to ensuring this cooperation, Regions will need to seek advice from universities on new issues, most notably the distribution of SIFT. RHAs and universities should ensure that appropriate mechanisms for effective collaboration between them are established.

1.5 SIFT is intended to meet the median excess service costs of undergraduate education and research in hospitals that support teaching, and should be clearly directed to that end. Regions or Districts as appropriate will disburse SIFT by means of contracts for facilities for undergraduate teaching and research to be entered into with directly managed units and NHS Trusts. They will collaborate with the relevant universities in setting these contracts and in ensuring that they are complied with. The Secretary of State for Health will also require information from Regions on Trusts' performance in these contracts to facilitate monitoring of the Trusts.

1.6 Each Region will also need to satisfy itself that District Health Authorities and Family Health Services Authorities have suitable consultation arrangements in place with universities for joint planning and management. Districts will need to ensure that units they manage have appropriate collaborative arrangements to provide effective service support for the delivery of teaching and research. Similarly, NHS Trusts with significant teaching commitments need to make appropriate collaborative arrangements.

1.7 We feel it is essential that all such arrangements between universities and the NHS comply with all of the ten principles. Liaison and consultation are not enough for effective collaboration. Both parties engaged in undergraduate medical and dental education must recognise their unity of purpose, and combine in a joint enterprise to achieve it.

1.8 We welcome improved information about local NHS commitments to support undergraduate medical and dental education. But we would not want to encourage either universities or the NHS in attempts to unravel "knock-for-knock" arrangements. In a teaching hospital, where NHS consultants and clinical academics engage in duties that inextricably mix patient care, teaching and research, we would oppose the introduction of expensive and time-consuming accounting mechanisms that could threaten harmonious and constructive working relationships. If there is pressure to change in this direction, then national guidance will be needed to prevent historical imbalances between universities and the NHS becoming the source of major local disruption.

2. INTRODUCTION:

Background

2.1 The Steering Group on Undergraduate Medical and Dental Education was originally established to consider the arrangements for planning and funding medical and dental education. But following publication of the NHS White Paper 'Working for Patients', we were asked to assess the implications of the proposed NHS reforms on these matters and to make recommendations. In developing our work we have borne in mind that paragraph 4.30 of the White Paper reaffirms the Government's commitment to maintaining the quality of medical education.

2.2 This report is the Steering Group's response to the changes outlined in the White Paper and other relevant developments in the National Health Service and universities. It subsumes our Interim Report, published in June 1989.

2.3 The education of undergraduate medical and dental students is primarily the responsibility of universities, and is funded by the Universities Funding Council. But teaching is carried out by both NHS and academic staff and requires the student and teacher to have regular access to patients. The National Health Service is responsible for the provision of the facilities that support the clinical portion of the undergraduate curriculum. Most of this NHS support for undergraduate education is provided in hospitals where the education of undergraduate students is inextricably linked with the general provision of services to patients.

2.4 The provision of undergraduate medical and dental education is thus based on a partnership between the universities and the National Health Service, which ultimately depend on funds voted by Parliament for distinct purposes. An added dimension is that the General Medical Council (GMC), and the General Dental Council (GDC), have statutory duties to promote high standards in undergraduate education in their respective disciplines. One of the ways in which they fulfil this role is by publishing recommendations on the undergraduate curricula of medical and dental schools.

2.5 In February 1987 the Croham Report on the University Grants Committee (which was succeeded in April 1989 by the Universities Funding Council) drew attention to the need for better coordination and planning of medical education at all levels. In November 1987 a conference involving the main bodies with direct interests in medical education established the Steering Group on Undergraduate Medical Education and asked it to consider how the arrangements for medical education could be improved. In April 1988 our remit was extended to encompass undergraduate dental education.

Interim Report

2.6 The initial phase of our work lasted until February 1989. Following a further

conference of the major bodies responsible for undergraduate medical and dental education in March 1989, we published an Interim Report in June 1989. The first (Interim) report covered the roles and responsibilities of those involved in undergraduate medical and dental education, the processes and the information required for planning. The Interim Report established important points of principle and made recommendations about what further work was needed, particularly in the light of the organisational changes in the NHS heralded by the White Paper. Its recommendations are summarised in Annex C.

The Next Stage

2.7 The second phase of the work of the Steering Group on Undergraduate Medical and Dental Education started in May 1989 when we agreed a programme of work aimed at addressing the new terms of reference that we had been given, which were:

> "Within the framework of the Government White Paper 'Working for Patients' to consider arrangements for undergraduate medical and dental education and the interaction of teaching, research and service activities; to consider how best to ensure that the policies and programmes of the bodies concerned are properly coordinated and managed; and to make recommendations."

2.8 The Steering Group included members drawn from all the major bodies that play a part in undergraduate medical and dental education. A list of the members of the Steering Group is in Annex A.

2.9 To take forward our programme of work expeditiously we made use of two 'task groups'. The Information Task Group was given the job of looking again at what data would be required for the improved joint planning recommended by the Interim Report.

2.10 The Implementation Task Group was used to develop proposals about financial and management arrangements for undergraduate medical and dental education arising from the changes resulting from the NHS White Paper.

2.11 Details of the terms of reference of the Task Groups and their membership are in Annex A.

NHS Review and other developments

2.12 The White Paper 'Working for Patients' made proposals for change aimed at improving the quality of services provided by the NHS, and the responsiveness of the NHS to the needs of patients. This report considers only those aspects of the reforms particularly relevant to undergraduate medical and dental education.

2.13 Most of the changes to the NHS that were relevant to the Group's work were

those concerned with the management, funding and organisation of hospital services. The White Paper proposed maximum delegation of operational responsibility to local level throughout the service. NHS Trust status would give suitable hospitals and units far greater freedom to manage their own affairs. But Trusts would remain firmly within the NHS and there will be safeguards, for example to ensure the continuation of a Trust's teaching functions. The roles of district health authorities would change significantly. In future they would concentrate on assessing the health needs of their resident populations and ensuring access to a comprehensive range of care to meet those needs. Districts would be funded according to the size and characteristics of their resident population and would commission services from providers. Hospitals for their part would be expected to provide high quality, value for money services as specified by health authorities. The viability of hospitals would be directly linked to the quality and efficiency of service provided to patients through contracts with health authorities.

2.14 The NHS and Community Care Bill was published in November 1989 and contained the legislative provisions required for certain of the changes described in the White Paper. A number of other new developments within universities and the NHS (including revised contractual arrangements for GPs) were also relevant to the work of the Group.

2.15 The Group has throughout been concerned to offer recommendations intended to ensure that the new arrangements in the NHS would not reduce the service support for undergraduate medical and dental education, but rather would allow that support to be sustained and enhanced, and equally would allow hospitals which provided such support not to be disadvantaged in pricing their services.

3. FUNDING:

Responsibilities

3.1 Public funding of undergraduate education is primarily the responsibility of the Department of Education and Science (DES). The Universities Funding Council (UFC) decides how the funds it receives from the DES are to be distributed to universities. Universities themselves determine how money from public and private sources is to be applied to their various activities. Undergraduate medical and dental education account for about one-fifth of all universities' total expenditure. In those universities that have schools of medicine and dentistry, their departmental expenditure accounts for up to one-third of all departmental expenditure.

3.2 The support that is provided for clinical teaching also leads to very significant costs within the NHS institutions closely associated with medical and dental schools. These costs do not only arise from the direct effects of the presence of students but also because these hospitals tend to be centres of excellence and sites for specialties not normally found in district general hospitals; because of the presence of research; and because of the accumulation of more complex cases and the more complex treatment of straightforward cases.

SIFT

3.3 The Department of Health compensates for the additional service costs of hospitals supporting undergraduate teaching through a payment known as SIFT, the Service Increment For Teaching. In Scotland, the Health Department makes a similar payment known as ACT, the Additional Cost of Teaching. In the absence of reliable information about how additional costs arise, the amounts paid by way of SIFT are assessed on information which compares the median costs of hospitals supporting teaching against those costs of district general hospitals with no significant teaching commitment. The White Paper 'Working for Patients' stated that the additional costs of health authorities involved in medical education would continue to be met through SIFT payments. While SIFT payments amount to less than one fifth of one per cent of the expenditure of the National Health Service as a whole, SIFT forms a substantial proportion of the funds available to (medical) teaching hospitals, in some cases as much as 20%. And for dental hospitals, SIFT is the source of between 80 and 95% of their total funding. Nationally, SIFT greatly exceeds the funds available to medical schools; in Great Britain in 1987/88, for example, medical SIFT (including ACT in Scotland) at £332 million was more than double the £130 million spent by universities on clinical medicine.

3.4 Until 1990/91 SIFT was intended to cover some 75% of the median excess costs of hospitals supporting undergraduate education. From 1990/1991, SIFT has been increased to meet 100% of the median excess costs of teaching hospitals. This provides explicit funding for the excess service costs of research in teaching hospitals for the first time. This significant change in the theoretical basis of SIFT will however amount only to a 2% increase in real terms. This is because the 1987

review of revenue allocation revealed that the difference in costs between teaching and non-teaching hospitals had narrowed, and SIFT was actually already meeting 98% of median excess costs.

3.5 The Group considered measures for improving the arrangements for the distribution of SIFT. Our recommendations are aimed at improving the way in which SIFT is directed explicitly towards sites supporting undergraduate education, and avoiding its use as a general subsidy to NHS teaching hospitals. The fundamental principle to be observed is that SIFT is intended to meet the additional service costs of undergraduate teaching and research in hospitals that support teaching, and should be clearly directed to that end.

3.6 The Group recommends that:

a. *SIFT should continue to be paid through health service channels,* because the payments relate to the excess costs of NHS service, and must therefore be tied to the service plans.

b. *SIFT should continue to be paid to Regional Health Authorities in proportion to clinical student numbers,* because, at regional level, student numbers are a simple but reasonably fair method of apportionment (although this may not be the case for that portion of SIFT used to support research in teaching hospitals, no better measure of excess service costs for research is available at present).

c. *Regional Health Authorities should consult universities with medical and dental schools, and other research interests, about the distribution of SIFT within regions,* because SIFT will be needed to support jointly agreed plans for medical and dental education and research (key principle x at 4.3 refers).

d. *In distributing SIFT sub-regionally, health authorities should take account of the following factors which affect how costs arise:*

i. the quantity and intensity of teaching activity;

ii. the extent of non-commercially funded research activity;

iii. the higher infrastructural costs of hospitals where a concentration of specialised expertise and facilities are needed to support, and have developed in response to, teaching and research;

iv. the extent to which teaching and research requires higher numbers of complex cases, and more complex treatment of straightforward cases.

Student numbers are too simplistic a measure to be used in isolation when considering the likely distributions at a local level. Examination of local academic and service plans and the arrangements for research will enable a better targeted distribution.

e. *SIFT should be paid by health authorities to units under an agreement which clearly specifies what educational and research support should be provided,*

because both universities and the NHS need an understanding of what is expected.

f. *Payment of SIFT should not give one part of the health service an unfair advantage over another when determining prices,* because SIFT is intended to secure support for undergraduate education and research, not to subsidise unfairly NHS service delivery.

3.7 The Secretary of State for Health has already accepted these recommendations, and the new procedures have been promulgated to the NHS.

3.8 The Group also *recommends that further work is undertaken to provide advice on:*

a. *better measures of the service costs of research* to improve distribution arrangements of that element of SIFT that is used for research;

b. *types of contract between health authorities and hospitals* for the specific service facilities in support of education and research that are to be provided in return for SIFT payments; and

c. *guidelines on how the NHS is to account for educational costs and SIFT payments* as part of the process of setting prices for patient services.

3.9 This requires a review of SIFT to be conducted, and it is discussed further in paragraph 7.4. We are aware that various suggestions have been made in relation to better measures of the service costs of research, and are being considered by the Department of Health. Another difficulty that has been identified is with providing service support for research in hospitals which do not receive SIFT, and we have noted the publication of a consultative paper by the Department of Health on this aspect. An efficient mechanism for supporting the service consequences of high quality clinical research is essential. Apart from the review of SIFT a further issue is that of the financing of tertiary referrals, and the Group notes that this problem is being considered by the Chief Medical Officer's Expert Advisory Group on Postgraduate and Continuing Medical Education. We recognise the importance of such referrals in maintaining a high quality of care as well as in facilitating clinical research.

Knock-for-Knock

3.10 Universities and teaching hospitals necessarily work very closely together. Apart from sharing premises and support services (such as laboratories), clinical staff of the university are involved in delivering NHS services to patients, while NHS staff are involved in teaching students. Universities and the NHS have not usually engaged in quantification and cross-charging when the staff of one perform duties for the other. The staff time involved has usually been treated as part of a 'knock-for-knock' or informal cost-sharing arrangement (though payments relating to support services are often apportioned between the parties). The NHS White Paper did not signal the end of such knock-for-knock arrangements, but there have been fears that the more rigorous accounting for

costs required as part of the reforms of the NHS would lead to teaching hospitals seeking to unravel and charge for the exact contribution of the parties.

3.11 The Group commissioned a study into the feasibility of unravelling knock-for-knock at one site, Southampton, with a view to preparing advice that could be issued generally. The study revealed that the costs of shared support services (such as laboratories, premises and student accommodation) were reasonably easy to disaggregate and apportion. The costs associated with patient care and educational duties of clinicians were much more difficult to apportion between the university and the hospital.

3.12 The main problems encountered in achieving a reliable apportionment of staff time are not amenable to objective resolution. A consultation with a patient is clearly part of NHS service delivery, but it might at the same time contribute to educational and research programmes. Getting staff to apportion their own time is expensive and time-consuming, and is inevitably distorted by subjective views of the relative importance of academic and service objectives within daily work schedules.

3.13 A number of developments lead us to believe that it will be easier to define and quantify the relative contributions of universities and the NHS to teaching and patient care in future. The White Paper announced the introduction of improved arrangements for job plans for NHS consultants. Once job plans have been used for a few years, they might become a source of data about the sessional commitments of both university and NHS clinicians. The introduction of explicit agreements for SIFT distribution (mentioned above) might also provide useful indicators about the academic contribution of NHS sites that receive SIFT. The introduction of contracts between health authorities and hospitals for NHS services could provide a basis for costing the contribution of university staff to service.

3.14 Although roles and responsibilities should be better defined, there will remain the difficulty of apportioning costs between patient care, teaching and research. We agreed with the study team that ever more sophisticated time measurement or cost accountancy techniques would always founder on the problem of disaggregating joint products and identifying which activity was being generated by whom and for what purpose. Ultimately, any apportionment of costs would need to involve a process of discussion and resolution based on agreement at specialty or sub-specialty level, as to respective contributions to all the patient care, research and teaching which it is intended should take place within that specialty.

3.15 But the Group was very concerned at the prospect of universities or the NHS seeking to introduce cross-charging for medical staff activities as they currently stand. It is likely that, across the country, the balance of contributions to service and teaching varies significantly between universities and teaching hospitals, simply as a reflection of historic arrangements for funding undergraduate medical and dental education at particular sites. If the parties involved seek suddenly and unilaterally to redress what they perceive as imbalances which have arisen in this way, then severe disruption to teaching, research and service will result. This would be disastrous, and must be avoided.

3.16 We were also concerned that expensive and time-consuming accounting mechanisms should neither threaten harmonious and constructive working relationships between university and NHS staff nor interfere with their work.

3.17 We did, however, see mutual benefits in defining with greater clarity the respective commitments to shared activities of universities and the NHS, to ensure that patient care delivered under contracts is effectively reconciled with medical education and research needs.

3.18 In the light of the above *the Group recommends:*

a. *that universities and the NHS should be discouraged from attempting to disaggregate knock-for-knock arrangements in respect of medical staff time by means of resource-consuming studies based on time measurement or cost accountancy techniques;*

b. *that there may well be value in better defining at specialty or sub-specialty level the support each party provides for the other's activities, so as to safeguard within each specialty the particular needs of patient care, teaching and research;*

c. *that it is essential that neither party uses the information derived through any clarification of contributions to demand payment for activities currently being provided under informal cost-sharing arrangements.*

3.19 It should be made absolutely clear to universities and the NHS that each will be expected to continue existing uncosted contributions to the other's areas of activity as at present. Changes in the balance of expenditure may only be made in an incremental way (eg: when a post falls vacant) and must be subject to agreement between the parties.

3.20 We have grave doubts about the feasibility and desirability of introducing widespread cross-charging in respect of medical staff time. If there were to be pressure for change in this direction, it would be essential that it was guided nationally and not introduced locally on a piecemeal basis. A transfer of resources at national level, or between institutions, or both would almost certainly be necessary. But we repeat that we would not support such a move at present. We recognise of course that this issue is yet to be fully resolved, and that it will therefore require further attention in the light of other developments.

3.21 And we would also re-iterate our recommendation (which we made first in our Interim Report) *that all new initiatives with financial implications for both sides should be costed and an apportionment agreed.*

3.22 *The Group recommends that arrangements for knock-for-knock are kept under review as the new contractual environment is introduced, and that any successor body to the Steering Group should play a leading role in identifying the need for any change to the existing arrangements, and, if necessary, guiding the implementation of any such change.*

3.23 The subject of knock-for-knock is discussed further in Section 5 (on Information Requirements) and in Section 7.

Dentistry

3.24 Dental hospitals treat patients at the same time as providing clinical facilities within which universities undertake clinical education. The funding arrangements for dental hospitals are, however, different from their medical counterparts. Most of the patients seen at dental hospitals would otherwise have received their treatment from a general dental practitioner, funded from the Family Practitioner Service and patient charges. Thus for the dental hospital service all the costs of such patients are 'excess' to those costs that would have normally arisen within the health authority. It has been estimated that, on average, only some 15% of the total costs of a dental hospital are costs that would have otherwise been borne within the health authority rather than the Family Practitioner Services.

3.25 Our recommendations concerning SIFT and knock-for-knock arrangements described above apply equally to dental education. We went on to consider what arrangements would be appropriate for funding that portion of a dental hospital's work not supported by SIFT. If funding for health authority referrals to dental hospitals was provided in a similar fashion to other NHS hospital services, then some 15% of a dental teaching hospital's funding would be provided as a result of treating patients under contracts with district health authorities. We were concerned that such a funding system should not threaten the volume and mix of cases needed to support dental education. We agreed that it was important that any financial regime provided secure funding at a level sufficient to cover the costs of the range of necessary referrals.

3.26 We asked the Department of Health to reconsider its proposal that a proportion of dental hospital funding should be met through contracts, because we were not confident that such a system would meet those objectives. We were subsequently told that it had been decided that dental hospitals should recover that element of their budget not met from dental SIFT through income from contracts. It was argued that adequate safeguards would exist to protect the position of dental education, and attention was drawn to the responsibility of Regional Health Authorities for ensuring that dental education continued to thrive.

3.27 The Group notes the decision that dental hospitals should recover that element of their budget not met from dental SIFT through income from contracts *and recommends that the impact of this decision on dental hospitals should be monitored by any successor body to the Group.*

Academic General Practice

3.28 University departments of general practice are different from other clinical disciplines because they work with a different part of the National Health Service. The NHS work of the GPs upon which such departments depends is paid for as part of the contract for services with the local Family Practitioner Committee. General practice academic staff treat patients under such a GP contract, and teach students as part of their employment with the university.

3.29 We acknowledged that in some places teaching in general practice may have been underfunded. In some cases academic departments had been supported almost entirely by 'soft' money. NHS support for teaching and research in general practice has also sometimes been less than satisfactory. The lack of explicit support (such as SIFT), or cost-sharing (such as knock-for-knock), has meant that the NHS was unable to cover shortfalls in academic infrastructure.

3.30 We welcome the contribution that changes in GP service payments could make to teaching in general practice, including:

a. explicit sessional payments for all GPs who teach students as part of their NHS duties;

b. a fund to protect the earnings of core university practices from some of the financial effects of the new GP contract.

3.31 It is the opinion of the Group that teaching in general practice is an integral and important part of the education of all medical students. The arrangements for funding academic general practice are more complex than for other academic disciplines. *The Group recommends that in the first instance any shortfalls in the academic infrastructure of general practice should be addressed within the university system.* Accordingly it hopes that the universities will carry out a detailed examination of their present arrangements.

3.32 To this end, we have accepted offers from the Universities Funding Council and the Committee of Vice-Chancellors and Principals to examine the problems of funding for university departments of general practice. The funding of teaching in general practice may need attention again later, not least because of the changed relationship between Family Health Services Authorities (which will succeed Family Practitioner Committees) and RHAs. The Group therefore *recommends that the funding of academic general practice should be monitored by any successor body to the Group.*

Capital charges

3.33 We noted that the NHS will be introducing a system whereby hospitals costs will include a charge for the use of capital assets. These charges will not be levied for assets at teaching hospitals which are owned by universities. NHS assets that have a mixed educational and service function will come within the scheme, and capital charges to take account of educational use of these assets will be funded through an enhancement of SIFT.

4. IMPROVED JOINT WORKING:

Unity of purpose

4.1 Undergraduate medical and dental education can only flourish as a joint enterprise between universities and the NHS. In our Interim Report we recommended the basic principles that should underpin this cooperation, and we also outlined some steps that could be taken to improve joint planning at a local and national level. In this report we are able to build on these foundations and offer further advice about the organisation and planning of undergraduate education.

4.2 We remain convinced that effective collaboration between universities and the NHS at all levels is essential for the maintenance and improvement of the high standards of medical and dental education and research. If collaboration is to be effective then information, liaison and consultation are not enough. Both parties must recognise their unity of purpose and jointly plan the service and educational arrangements towards their shared objectives.

Key principles

4.3 In order to define better the shared goals of universities and the NHS, the Group developed the principles that we had put forward in our first report. Whatever organisational arrangements are agreed locally, *the Group recommends that both the universities and the NHS should be guided by ten key principles:*

i. the aim of undergraduate medical and dental education is to produce doctors and dentists who are able to meet the present and future needs of the health services; to this end, future doctors and dentists should be educated in an atmosphere which combines high professional standards (set by the GMC/GDC) with a spirit of intellectual enquiry and innovation based on active research and development programmes;

ii. the universities and the NHS have a shared responsibility for undergraduate medical and dental education;

iii. undergraduate medical and dental education should be provided efficiently and cost-effectively within the programmes of the universities and the NHS;

iv. the local provision of undergraduate medical and dental education should be guided by clearly defined and coordinated national policies;

v. local policies and plans relevant to undergraduate medical and dental education should be agreed and regularly reviewed by both parties; once established, local policies and plans should be disseminated;

vi. the planning and review process for undergraduate medical and dental education should involve senior staff in universities and the NHS, and other relevant bodies;

vii. information required for the formulation of plans and reviews should be shared by both sides;

viii. in their plans the universities and the NHS should take into account the implications of research for teaching and service provision, and should foster both the application of current research and the development of high quality new projects;

ix. the universities and the NHS should consult each other on the nature and special interest of senior medical appointments;

x. SIFT (or ACT in Scotland) should be allocated on the basis of jointly agreed service plans to support teaching and research.

4.4 These principles have been endorsed by the Secretaries of State for Health, for Education and Science and for Scotland and have been promulgated to the NHS and to the universities.

Local organisation

4.5 In our first report we examined the possibility that the administration, funding and management of undergraduate medical and dental education could be simplified by bringing the separate responsibilities of the universities and the NHS together within one organisation. Our conclusion then was that the potential advantages of such an arrangement were outweighed by the practical problems that would be caused for undergraduate education and the NHS. We have not changed our view. But we have examined some important questions about joint management and planning.

4.6 We considered a large number of organisational arrangements for medical and dental education in order to establish how the key principles could best be reflected locally. We looked at existing organisational models ranging from those where medical schools and teaching hospitals were closely integrated to others where two distinct organisations met and cooperated only to the extent required for joint planning. We also looked at theoretical models for organisational arrangements, especially at the 'MERG' (Medical Education and Research Group) structure proposed by the Committee of Vice-Chancellors and Principals.

4.7 We concluded that any and all of the actual and proposed variants of organisation had the potential to address the ten key principles and to deliver the shared educational goal. Our only disquiet related to those arrangements which rely on informal and unwritten consultation for agreeing the allocation and apportionment of responsibilities and resources. We believe that in some cases such arrangements may prove insufficiently robust for the effective management of undergraduate medical and dental education, in the changed circumstances resulting from the NHS White Paper.

4.8 *The Group therefore recommends that universities and the NHS should be free to agree locally what organisational arrangements they will use, provided that all such arrangements clearly adhere to the ten key principles.*

4.9 *The Group further recommends that universities and the NHS should review their existing organisational arrangements, particularly in cases where a teaching hospital is seeking NHS Trust status, or where existing arrangements have relied on informal consultation between individuals.*

4.10 Our detailed advice on the merits of various local approaches to organising medical and dental education is at Annex B. This advice, too, has been endorsed by the Secretaries of State and promulgated. Our advice about national monitoring of arrangements is in section 7.

Consultation arrangements

4.11 Our advice on organisation and joint planning is intended to ensure that universities and the NHS should agree arrangements for all those aspects of the work of each which could affect the work of the other. Nevertheless, we want to highlight aspects of joint working that have attracted our particular attention.

4.12 Our recommendations concerning SIFT give the universities a role in deciding the distribution of payments from regional health authorities. Such an annual review of funding for the NHS contribution to medical and dental education could go a long way towards reducing the tensions between universities and the NHS that appear from time to time. We believe that these discussions should occur as part of a continuing planning and review process involving both parties. But if consultation and joint planning occur less often than they should, then at least the annual discussions about SIFT should focus attention on shared objectives.

4.13 We recommended in our Interim Report that the position of Regional University Liaison Committees should be reviewed. As a result of our recommendations about local organisation above, *the Group recommends that the remit and membership of Regional University Liaison Committees should be agreed locally, and that there should not be any obligation or requirement for universities and the NHS to form such committees if they have other satisfactory mechanisms for consultation and planning.*

4.14 This recommendation does not apply to Scotland where the existing University Liaison Committees will be reinforced to act as a mechanism for consultation and cooperation, particularly in relation to the annual distribution of ACT monies.

Interim report recommendations

4.15 There were other recommendations in our Interim Report which have yet to be fully implemented. We review some of them here.

4.16 We recommended that medical and dental schools should have devolved budgets. We re-iterate this recommendation, particularly in the light of the ten key principles. Universities and their medical schools will be better placed to draw up plans for undergraduate medical and dental education with the Health Service if the resources available to them are known, and if they have a degree of devolved budgeting authority. Moreover, this recommendation is consistent with the recommendation of the Jarratt report on efficiency studies in universities, which also noted that the corollary of delegated budgeting is responsibility for what is achieved.

4.17 The Interim Report also recommended that Deans of Medical and Dental Schools should be members of the university planning and resources committee. We made this recommendation because we believe that effective joint planning and funding is essential to underpin medical and dental education, and that joint planning for medicine and dentistry can only become a reality if it is closely linked to planning in the university as a whole. But we recognise that many universities have chosen not to include budget holders on this committee. In these cases the interests of medical and dental faculties could be represented in other ways, acknowledging that the development of these subjects takes place alongside the remainder of the university.

NHS Trusts and district health authorities

4.18 We noted that, as part of the reform of the NHS, all health authorities will be reconstituted on more businesslike lines. Members of authorities will be selected by reference to the personal contribution they can make to the management of the authority (rather than their representational status). The NHS Bill will not change the status of teaching districts. We were informed that teaching districts will continue to include someone drawn from the associated university. In a similar fashion, where an NHS Trust is formed which has a substantial commitment to medical or dental teaching, one non-executive director will be drawn from the university. Such a Trust will have a specific reference to its teaching role in its establishment order, placing an obligation on all its directors to see that role discharged.

National arrangements

4.19 In our Interim Report we recommended that national policies for medical and dental education should be coordinated, and that published guidance should be consistent with these policies. The Group has itself been the focus for the development and coordination of national policies for the last two years. Guidance has been developed within the Group. By consulting both academic and service interests, we have endeavoured to ensure that guidance is both internally consistent, and also compatible with the policies of universities and the NHS. In section 7 we consider what arrangements might be suitable for ensuring policy is properly coordinated in future.

5. INFORMATION REQUIRED FOR PLANNING:

Background

5.1 Our earlier recommendations on the information required for planning are at Annex C. The importance of these has been emphasised by our subsequent work. In particular the procedures for the distribution of SIFT and the ten key principles point to the need for a sound information base.

5.2 The primary need for information is as a basis for planning undergraduate medical and dental education at local level. A common core of information available to all those engaged in the provision of undergraduate medical and dental education - primarily the teaching hospitals and medical and dental schools - should provide a framework within which collaboration can continue to flourish. At the same time there is a need for the providers of undergraduate medical and dental education to account for the funds given them - and the efficiency and effectiveness of their services - to their financial sponsors and to the general public.

5.3 We therefore envisage that the primary suppliers and users of data will be the medical schools and teaching hospitals, the data assisting them in monitoring and evaluating their aims and objectives. We advocate collecting data for national or regional monitoring that are seen to be directly relevant at the local level. But local data can be exploited to much greater effect if they are collected according to nationally agreed definitions and standards.

Universities Statistical Record

5.4 Much, but not all, of the information that we consider necessary to achieve a common planning base is already available within existing university statistical sources on staff, students and finance, details of which were published in an annex to our first report. It will be essential to ensure, as far as possible, that data are drawn together, or newly collected, in a systematic and coherent way and made widely available to both medical and dental schools, health authorities and others. By maximising use of current sources and local developments, data costs should be kept to a minimum. *The Group recommends the adoption in the longer term of the University Statistical Record (USR) and the UFC's income and expenditure survey as the foundations on which to assemble necessary data and information.*

5.5 The Information Task Group has identified for us a number of tasks requiring further attention:

a. There is a need to measure undergraduate student load in each hospital within the regions, taking account of clinical specialties. This is important in planning teaching and teaching-related research in hospitals associated with medical and dental schools, and consequently in apportioning SIFT. *The Group recommends mounting pilot surveys in a small number of teaching*

districts in order to devise satisfactory procedures for measuring undergraduate student load by specialty.

b. Staff data will also be relevant for SIFT. The development of staff job plans and teaching contracts will assist in quantifying the level and intensity of undergraduate teaching at the places where it is provided. We recommend (in paragraph 7.4) that further work is undertaken towards a review of SIFT in 1992. This gives added weight to the Group's *recommendation that the USR Staff Record for medical and dental academic staff be enhanced and that proposals for such an enhancement be prepared.*

c. Any system providing complete information on net expenditure on undergraduate medical and dental education would depend upon a full quantification of 'knock-for-knock' arrangements. We have concluded (paragraphs 3.10 to 3.23 refer) that such quantification is not feasible or desirable at present. But the recent Southampton Study suggests that, with the important exception of staff time, there should be few difficulties in putting a value on the uncosted services provided by each side. The Group *recommends that the Universities Funding Council amends its financial procedures so that adequate recognition of costed services relating to medical and dental provision is made in universities' income and expenditure accounts.*

d. Although, bearing in mind our terms of reference, we have given only passing consideration to postgraduate education, we are in no doubt that a small amount of data on postgraduate activity is required. The Continuing Education Record (CER) maintained by the USR is a possible source but is recognised as unsatisfactory in its present form as a source of information on postgraduate medical and dental training courses, mainly for reasons of coverage and content. It needs to focus more sharply on activities which are recognised by the Royal Colleges, which involve clinical teaching effort, and which involve NHS funding. *The Group recommends that the coverage and content of the Continuing Education Record for medical and dental education be reviewed and proposals for its enhancement be prepared, taking account of the interests of SCOPME.*

Job Plans as a data source

5.6 The largest single factor affecting the cost of undergraduate medical and dental education is staff expenditure on teaching, and teaching-related research. Identifying the net teaching and research staff load is therefore important in planning and managing the delivery of medical and dental education.

5.7 Both NHS clinical and non-clinical staff are involved in undergraduate teaching. Clinical academic staff typically have patient care responsibilities. One way to derive estimates of net teaching load would be through a diary exercise completed by individual members of staff. But such a survey would be burdensome and there could be no guarantee of reliable results. We reject that approach. An alternative method would exploit the information contained in job-

plans and contracts. *The Group recommends that pilot projects on the use of job-plans and contracts data be mounted as soon as practicable and appropriate.*

5.8 Provided that job-plans were reviewed regularly, and updated appropriately, the commitments underlying the contracts (measured in terms of sessions of different types) could be collated to form staff job plan data-bases. Each data-base would be defined and assembled locally, and form a reservoir of data on clinical and academic staff teaching and teaching-related research.

5.9 A cost-effective way of collecting the job-plan data would be to extend the USR academic staff record, both in coverage and content. It would also minimise the need for extra data collection. The enhancement of coverage would be to include all NHS clinical staff with specific teaching (or teaching-related research) commitments. As regards content, each member of academic staff on the record would have, as appropriate, the number of sessions committed to teaching, research and patient care. *The Group therefore recommends that the proposed enhancement of the USR Staff Record looks to job plans and contracts as its basis.*

5.10 By using these data in conjunction with information on student load, it will be possible to quantify the net costs of undergraduate medical and dental education with more accuracy than has been possible hitherto. The UFC has accepted that it has a key role in this development.

5.11 The medical and dental schools would continue to be best placed to assist the university in completing this expanded USR staff return. All would have access to suitably anonymised aggregate data. The USR at Cheltenham would continue to process the staff return under appropriate contractual arrangements and the UFC, using agreed methodologies, would estimate net teaching load and compile relevant statistics.

5.12 It is not yet clear whether the contribution of other staff to undergraduate teaching will be included explicitly in job-plans and contracts. *The Group recommends that consideration be given to including the teaching contribution of all staff in the proposed job-plan data-bases.*

Further Work

5.13 Our recommendations point to further work being done prior to the formation of the Standing Working-Group recommended in our first report. The immediate work would be to pursue the initiatives we have recommended, and to assemble partial information and at the same time to draw up model annual reports to be produced for each school and teaching district, and nationally. *The Group recommends that a small Working Group should be appointed to take forward our recommendations on information requirements and should report to any successor body to the Group.*

6. OTHER MATTERS:

Job plans for consultants

6.1 As part of the reform of the NHS following the White Paper, the Government has proposed a system of job plans for all hospital consultants. The most important change for us was the proposal to introduce statements of consultants' agreed commitments to service, teaching and research under their NHS contracts. This change would enable academic departments to plan the student curriculum based around defined levels of support from NHS colleagues. We also considered the effect of these proposals on clinical academic staff holding honorary contracts with the NHS. We were concerned that university staff may not be able to make defined service commitments to the NHS without a greater degree of flexibility than their NHS colleagues. We noted that the Health Departments proposed to advise health authorities to allow more flexibility. Among possible approaches to achieve such flexibility we suggest that universities and the NHS would agree a tightly defined package of clinical service commitments to be delivered by university staff under the management of heads of clinical academic departments in consultation with NHS general managers. The number of fixed commitments to be included in each individual's job plan would be agreed by the individual concerned, the general manager and the head of the academic department. *The Group recommends that further work be done in the light of Departmental guidance to devise suitable arrangements for job plans for the service commitments of staff in clinical academic departments.*

Primary and community care education

6.2 In our first report we recommended that we should explore the implications of an increase in primary and community care as part of the changing pattern of medical services. We have already discussed teaching in general practice in the earlier section on 'Funding'. Further monitoring is necessary, and we return to this in Section 7 below.

Postgraduate education and research

6.3 In our first report we recommended that further work be undertaken to consider postgraduate education and research insofar as they are linked to and affect undergraduate education. In several areas of our work we have needed to take account of postgraduate education and research, for example in the enhancement of SIFT and our study of knock-for-knock. We were aware, however, that other potential changes in the arrangements for postgraduate education and research were being discussed outside the Group, for example in the Standing Committee on Postgraduate Medical Education and in the Chief Medical Officer's Expert Advisory Group on Postgraduate and Continuing Medical Education. We did not, therefore, undertake any further work in these areas. We make further comment about research when discussing future coordination arrangements in Section 7 below.

Funding of universities

6.4 There have been two recent changes in the funding of universities. First, the Government has announced a change in the balance of public support for universities between the block grant paid through the UFC and the tuition fee paid as part of the mandatory awards arrangements. From academic year 1990/91 the undergraduate fee paid by local authorities on behalf of students holding mandatory awards will be increased from some £600 to £1675 with a corresponding abatement of the grant paid to the UFC. Insofar as universities recruit as many mandatory award holders as the Government projects, the effect will be neutral. But the intention is to encourage universities to exploit marginal teaching capacity in all subjects except those, like medicine and dentistry, whose intake is controlled by Government. From academic year 1991/92 the publicly-funded fee will be differentiated into three bands which reflect the different costs of teaching classroom-based, laboratory-based and clinical subjects. But there will be no shift away from the block grant in respect of students who are not mandatory award holders.

6.5 Second, the UFC is introducing a new procedure for distributing that part of institutions' block grants allocated on teaching-based criteria. Essentially, institutions have been invited to bid for student places against a maximum guide price based on current average costs. Because of the limit on student intake, undergraduate places in medicine and dentistry will be outside the bidding system, and funding will be at the guide price for the places in all years based on the intake of students. There may, however, be small consequential effects resulting from a university's relative success in gaining student places in other subjects.

6.6 In addition, the UFC is to alter the weighting given to the factors used to distribute funds in block grants on research based criteria: less emphasis will be accorded to student numbers, and greater emphasis to judgements of the quality of research carried out in each subject in each university. At the same time, the Government is consulting interested parties about a shift in the balance in the dual support system for funding university research. The Government proposes that Research Councils should be responsible for all the additional costs of the research projects they fund, with the exception of academic staff and premises costs. The change in arrangements would be accompanied by a modest transfer of funds from the UFC to the Science Budget. The Government does not intend that these proposals should change the basis on which charities provide support for research in higher education institutions.

Other university matters

6.7 We noted the suggestion that students can have an important role in commenting on and planning undergraduate medical and dental education. Already the GMC working party reviewing the 1980 recommendations on the medical curriculum has sought the nomination of a student representative, and universities will wish to take appropriate account of guidance from, and standards and systems needed to satisfy, the CVCP's Academic Audit Unit. In these and other ways universities

may want to take account of the views of students before settling joint plans with the NHS.

6.8 In our first report we recommended that there should be further investigation of the impact of the increase in the number of university staff funded by charities and other non-Exchequer organisations. We are content that this matter is being dealt with elsewhere in the wider context of discussion of research.

7. THE FUTURE:

The future of the Steering Group

7.1 We have spent the last year coordinating the development of policies for medical and dental education during the period following the publication of the NHS White Paper. We feel that there will be a similar need for national coordination as changes in the NHS are implemented. *The Group recommends that arrangements for a broadly-based coordinating body for policy in the field of undergraduate medical and dental education be continued,* at least for the next two years while the NHS reforms are implemented.

7.2 In addition to SIFT and knock-for-knock, which are mentioned below, the national coordinating body will need to monitor and review the impact of changes in the NHS and universities on arrangements for undergraduate medical and dental education (including the implementation of measures adopted as a result of this report). For example, such a body could monitor the impact of changing patterns of medical care, especially care in the community, on education (as mentioned in our first report, and in section 6 above).

7.3 Research is outside our terms of reference (except insofar as it affects undergraduate education). But the Group *recommends that consideration be given to having clinical research with service implications (including health services research) within the remit of the proposed national coordinating body for undergraduate medical and dental education.*

Review of SIFT

7.4 We recommended, and the Department of Health has accepted the need for, a review of SIFT to be completed by 1992. This review is to evaluate the changes that have taken place recently, consider options for improving targeting (for support of research in particular), and assess how well SIFT works in the light of the general changes in funding hospitals. Apart from this review (which we welcome), our own work leaves outstanding questions regarding contracts for SIFT, and how SIFT is taken into account in pricing NHS services. *The Group recommends that further work is undertaken towards completion of a review of SIFT by 1992.*

Knock-for-Knock

7.5 While we felt it would be unwise to advocate radical change to knock-for-knock arrangements, we do feel that changes in university and NHS funding could put such arrangements under increasing pressure. We have made a series of recommendations designed to prevent the system collapsing. *The Group recommends that any successor body should be closely involved in whatever changes may be proposed to the knock-for-knock arrangements.*

8. CONCLUSIONS AND SUMMARY OF RECOMMENDATIONS

8.1 In this report we have made many recommendations, which are summarised below, concerned with important facets of the arrangements for medical and dental education. We would not want the details of these proposals to detract from the most important message-universities and the NHS must share a common purpose to maintain and improve standards of undergraduate medical and dental education. Organisational and funding arrangements must encourage an environment where university and NHS staff combine in a joint enterprise to teach students, advance knowledge, and improve service to patients. In summary we make 33 recommendations as follows.

8.2 The Group recommends that:

i. SIFT should continue to be paid through health service channels (para 3.6.a);

ii. SIFT should continue to be paid to Regional Health Authorities in proportion to clinical student numbers (para 3.6.b);

iii. RHAs should consult universities with medical and dental schools, and other research interests, about the distribution of SIFT within regions (para 3.6.c);

iv. in distributing SIFT sub-regionally, health authorities should take account of the quantity and intensity of teaching activity; the extent of non-commercially funded research activity; the higher infrastructural costs of hospitals where a concentration of specialised expertise and facilities are needed to support, and have developed in response to, teaching and research; and the extent to which teaching and research requires higher numbers of complex cases and more complex treatment of straightforward cases (para 3.6.d);

v. SIFT should be paid by health authorities to units under an agreement which clearly specifies what educational and research support should be provided (para 3.6.e);

vi. payment of SIFT should not give one part of the health service an unfair advantage over another when determining prices (para 3.6.f);

vii. further work is undertaken to provide advice on better measures of the service costs of research; on types of contract between health authorities and hospitals; and on guidelines on how the NHS is to account for educational costs and SIFT payments (para 3.8);

viii. universities and the NHS should be discouraged from attempting to disaggregate knock-for-knock arrangements in respect of medical staff time by means of resource-consuming studies based on time measurement or cost accountancy techniques (para 3.18.a);

ix. there may well be value in better defining at specialty or sub-specialty level the support each party provides for the other's activities, so as to safeguard within each specialty the particular needs of patient care, teaching and research (para 3.18.b);

x. it is essential that neither party uses the information derived through any clarification of contributions to demand payment for activities currently being provided under informal cost-sharing arrangements (para 3.18.c);

xi. all new initiatives with financial implications for both sides should be costed and an apportionment agreed (para 3.21);

xii. arrangements for knock-for-knock are kept under review as the new contractual environment is introduced, and that any successor body to the Steering Group should play a leading role in identifying the need for any change to the existing arrangements, and, if necessary, guiding the implementation of any such change (para 3.22);

xiii. the impact of the decision that dental hospitals should recover that element of their budget not met from dental SIFT through income from contracts should be monitored by any successor to the Group (para 3.27);

xiv. in the first instance any shortfalls in the academic infrastructure of general practice should be addressed within the university system (para 3.31);

xv. the funding of academic general practice should be monitored by any successor body to the Group (para 3.32);

xvi. both the universities and the NHS should be guided by ten key principles for improved joint working (para 4.3);

xvii. universities and the NHS should be free to agree locally what organisational arrangements they will use, provided that all such arrangements clearly adhere to the ten key principles (para 4.8);

xviii. universities and the NHS should review their existing organisational arrangements, particularly in cases where a teaching hospital is seeking NHS Trust status, or where existing arrangements have relied on informal consultation between individuals (para 4.9);

xix. the remit and membership of Regional University Liaison Committees (in England) should be agreed locally, and that there should not be any obligation or requirement for universities and the NHS to form such committees if they have other satisfactory mechanisms for consultation and planning (para 4.13);

xx. in the longer term, the University Statistical Record (USR) and the UFC's income and expenditure survey should be adopted as the

foundations on which to assemble necessary data and information (para 5.4);

xxi. pilot surveys in a small number of teaching districts should be mounted in order to devise satisfactory procedures for measuring undergraduate student load by specialty (para 5.5.a);

xxii. the USR Staff Record for medical and dental academic staff be enhanced and that proposals for such an enhancement be prepared (para 5.5.b);

xxiii. the UFC amends its financial procedures, so that adequate recognition of costed services relating to medical and dental provision is made in universities' income and expenditure accounts (para 5.5.c);

xxiv. the coverage and content of the Continuing Education Record for medical and dental education be reviewed and proposals for its enhancement be prepared, taking account of the interests of SCOPME (para 5.5.d);

xxv. pilot projects on the use of job plans and contracts data be mounted as soon as practicable and appropriate (para 5.7);

xxvi. the proposed enhancement of the USR Staff Record looks to job plans and contracts as its basis (para 5.9);

xxvii. consideration be given to including the teaching contribution of other staff in the proposed job plan data-bases (para 5.12);

xxviii. a small Working Group should be appointed to take forward our recommendations on information requirements, and should report to any successor body to the Group (para 5.13);

xxix. further work be done to devise suitable arrangements for job plans for the service commitments of staff in clinical academic departments (para 6.1);

xxx. arrangements for a broadly-based coordinating body for policy in the field of undergraduate medical and dental education be continued (para 7.1);

xxxi. consideration be given to having clinical research with service implications (including health services research) within the remit of the proposed national coordinating body for undergraduate medical and dental education (para 7.3);

xxxii. further work is undertaken towards completion of a review of SIFT by 1992 (para 7.4);

xxxiii. any successor body should be closely involved in whatever changes may be proposed to knock-for-knock (para 7.5).

8.3 The recommendations in paragraphs 8.2.i to vi and xvi to xix have already been endorsed by the Secretaries of State, and promulgated.

MEMBERSHIP AND WORKING METHODS

STEERING GROUP

1. The membership was:

Chairman - Sir Christopher France, Permanent Secretary, Department of Health

Committee of Vice Chancellors & Principals

Professor T J H Clark
Professor Sir Herbert Duthie
Professor G P McNicol
Professor R Storer
Miss B Crispin (1)
Mr A M A Powell

General Medical Council
Professor D A Shaw
Mr P L Towers

General Dental Council
Mrs J M Gordon

Universities Funding Council
Professor Sir Colin Dollery
Mr J H Farrant
Mr G M Wolfson (2)

Standing Committee on Postgraduate Medical Education
Professor Dame Barbara Clayton

Secretariat
Mr J G Gooderham - DH
Mr M F Hipkins - DES
Mr D A Pink - DH

NHS
Mr T Hunt
Dr J M O'Brien
Mr K Punt

Department of Education & Science
Mr J M M Vereker
Mr W B Wakefield

Department of Health
Sir Donald Acheson
Miss S Bateman
Mr N Duncan
Dr A J Isaacs
Mr D W Lye
Mr J A Thompson
Dr D Walford

Scottish Home and Health Department
Mr K J MacKenzie
Dr A B Young

2. The membership of the Steering Group changed slightly over this phase of work:

(1) was replaced by Mr Powell

(2) was replaced by Mr Farrant

3. It met six times during this phase of its work. In addition, its work was informed by its chairman meeting with several groups with an interest in this field including the BMA's Conference of Medical Academic Representatives, the Joint Medical Advisory Committee of the University of London, the Joint Conference of Metropolitan and Provincial Deans, the General Medical Council, the Academic Medicine Group, representatives of academic departments of general practice, the General Dental Council, the Committee of Vice-Chancellors and Principals, Chairmen of the London Health Authorities and the Medical Research Council.

4. It considered submissions from some of these, namely, the Joint Medical Advisory Committee of the University of London, the Joint Conference of Metropolitan and Provincial Deans, the representatives of academic departments of general practice and the Medical Research Council along with others including the medical students in Manchester Medical School.

IMPLEMENTATION TASK GROUP

5. Chairman - Dr A J Isaacs, Senior Principal Medical Officer, Department of Health

Committee of Vice Chancellors and Principals
Professor T J H Clark
Professor P D Griffiths
Professor R Storer
Professor L A Turnberg
Miss B Crispin (1)
Mr A M A Powell

General Medical Council
Mr P L Towers

General Dental Council
Mrs J M Gordon

Universities Funding Council
Mr J H Farrant
Mr G M Wolfson (3)

Standing Committee on Postgraduate Medical Education
Dr G Ford

Secretariat
Mr P Ahearn
Mr D Pink

NHS
Mr T Hunt
Dr J M O'Brien

Department of Health Nominees
Professor J D Baum
Mr M H Collier
Mr M Else
Professor J MacVicar
Professor D H Metcalfe
Dr B L Pentecost

Department of Education & Science
Mr M F Hipkins
Mr W B Wakefield

Department of Health
Dr J Ashwell
Miss S Bateman
Mr N Duncan
Mr J G Gooderham
Mr D Lye
Mrs J Mixer

Scottish Home & Health Department
Mr C K McIntosh
Miss N Munro (2)
Dr A B Young

6. There were several changes:

(1) was replaced by Mr Powell

(2) was replaced by Mr McIntosh

(3) was replaced by Mr Farrant

7. The Steering Group used its Implementation Task Group to develop proposals about financial and management arrangements for it to consider. This Task Group met six times, in between the Steering Group meetings. This method of working allowed the Steering Group to issue its recommendations periodically and keep in step with the Government's timetable for developing its reforms of the NHS.

8. Its terms of reference were:

> "To develop the proposals outlined in the White Paper 'Working for Patients' as they affect undergraduate medical and dental education, and its interaction with research and service; to consider other issues which may be identified by the Steering Group; and to make recommendations".

INFORMATION TASK GROUP

9. Chairman - Mr W B Wakefield, Director of Statistics, Department of Education and Science

Committee of Vice Chancellors and Principals
Dr A W Roberts
Mr P Gayward
Mr K Davies

General Dental Council
Mrs J M Gordon

Universities' Funding Council
Dr S Nandy
Mr G Whitfield

Secretariat
Miss C F Maddern

NHS
Mr J Bacon
Mr K MacLean
Mr R Freer
Mr G Mitchell

Department of Education & Science
Mr H M Dale
Mr T C Knight
Mr M F Hipkins

Department of Health
Dr J Ashwell
Mr D Rees
Mrs A Goddard
Mr J G Gooderham

Scottish Home & Health Department
Mr E MacKay

Welsh Office
Dr M Pepper
Mr J Kinder

10. It formed a Subgroup comprising:

Chairman - Mr H M Dale, Department of Education and Science

Universities and Medical Schools
Dr A W Roberts
Mr R J Graham
Mr P Gayward

Universities' Funding Council
Mr G Whitfield
Dr S Nandy

NHS
Mr A Cundy

Department of Education and Science
Mr T C Knight

Department of Health
Mr D Rees

11. This list represents the final membership. Four members were replaced over this period: Mr T C Knight replaced Mrs E Mellor (at the DES); Mr G Whitfield replaced Mr T C Knight (at the UFC); Dr S Nandy (UFC) attended in place of Mr G Wolfson, and Dr J Ashwell replaced Dr J Lissamore (at the DH).

12. The Information Task Group's terms of reference were:

> 'To aim to improve the current information base on undergraduate medical and dental education by April 1991 and make proposals for its subsequent development taking into account in both cases the information needs arising from the new funding arrangements to be introduced through implementation of the White Paper "Working for Patients". The proposed changes should cover postgraduate education and research insofar as they are linked to and affect undergraduate education. All proposals should be cost-justified.'

13. The Task Group met three times during this period. In addition, its work was informed by a meeting between its chairman and the CVCP.

14. The Information Task Group appointed a Subgroup to develop specific proposals on information requirements and availability for it to consider. The Subgroup's terms of reference were:

'To examine :

1. The needs of medical and dental schools in accounting for student activity, staff deployment, and finance;

2. The needs for information at the national level;

3. How a data-collection system would operate within the medical schools, and the definitions to be employed;

4. To examine the costs involved in relation to (1) and (2).'

15. The Subgroup met four times and produced two reports to the Information Task Group.

ORGANISATIONAL MODELS

Introduction

1. This note provides illustrations of ways in which universities and the NHS can locally organise and coordinate their activities in the field of undergraduate medical and dental education. The note describes three basic models for the local organisation of undergraduate medical and dental education and the way in which these different organisational arrangements might perform in the future.

Range of models

2. The three broad types of organisational arrangements are illustrated by reference to particular examples, with the strengths and weaknesses of each type highlighted. There are organisations that:

   a. integrate their responsibilities and resources for education and service;

   b. "pool" some responsibilities and resources;

   c. apportion their responsibilities and resources.

Integrated resources

3. Where a teaching hospital integrates completely the management, funding and delivery of education and service, common goals are agreed including the delivery of high quality care to patients and the education of students to high standards. The common goals are reflected in an integrated staffing structure with academic departments and service divisions having a single head, who may be either an academic or a consultant.

4. The Hammersmith Hospital and the Royal Postgraduate Medical School are an example of complete integration of service delivery and education (in the postgraduate area). Chairmen of the major academic clinical departments are also Chiefs of Service and have a dual responsibility to the SHA and school. This system imposes a considerable administrative burden on the school but the SHA provides substantial administrative support. An advantage of this system is that it provides a unified and effective chain of command on both the clinical and academic sides.

5. At the United Medical and Dental Schools of Guy's and St Thomas's Hospitals there is a less complete, but still considerable, degree of integration. The main strength of integrated organisation is that it fosters unity of purpose. However there may be some drawbacks if one set of priorities were to become dominant over the other. This type of organisation might also be less applicable to the teaching taking place outside the main teaching hospital ie: in district general hospitals, primary care settings and the community.

6. While it might therefore not be possible to replicate exactly the Hammersmith arrangements in the undergraduate setting, integration is both feasible and desirable. For example, NHS Trusts formed by teaching hospitals elsewhere might want professorial heads of service and academic departments, though the main purpose of the organisation would be service delivery.

Pooled resources

7. A second way of organising undergraduate medical and dental education is for universities and the NHS to "pool" a certain quantity of their resources for joint use. In contrast to integrated organisations, service delivery and education retain their separate identities. A formal decision-making process is needed to produce agreements as to the extent to which resources are pooled and the purposes for which they are to be used.

8. The system of joint management and planning in operation at Cambridge provides a good example of pooling resources, and the CVCP's suggestion for a Medical Education and Research Group (MERG) is another. The best features of this type of organisation are the clear definitions of joint decision-making that are present. The pooled resources organisation would be robust to change and thus well suited to the reformed NHS where more vigorous definitions of responsibilities and costs are needed.

Apportioned resources

9. There are other ways of organising undergraduate medical and dental education which do not involve such precise definitions of the respective roles of universities and the NHS. Where formally convened meetings exist they may not have authority to make planning decisions, and often the division of resources and responsibilities are discussed by direct personal contact between Deans and General Managers. Where formal arrangements do exist, they may be limited to consultation and liaison because authority to make decisions is not delegated, as with Regional University Liaison Committees.

10. Variations on this theme are exhibited in many locations. The strength of this type of arrangement is that it enables close working relationships to flourish without the addition of imposed frameworks and thus encourages flexible management. But there are also disadvantages in this method of working. There can be a reliance on established personal relationships between medical school and teaching hospital staff, which is vulnerable to personnel changes. And particular problems arise when one party is obliged to take important resource decisions which affect the other. The apportioned resources previously agreed may become unbalanced with severe consequences.

11. The apportioned resources model is an illustration of current practice that has worked well, but it may not be sufficiently resilient to changes that might be required following the implementation of NHS reforms, or if knock for knock were to be disaggregated. In the face of such developments, universities and the NHS will need to ensure resourcing and division of responsibilities is on a sound,

explicit and formally agreed basis. Even so, good personal relationships are valuable and necessary; but they cannot alone be guaranteed to produce the desired effect and should be regarded as essential whatever other form of organisation is in place.

Future

12. The local organisation of undergraduate medical and dental education will be affected by several forthcoming changes, for example:

    a. As described in EL(89)MB/199, SIFT is being increased, and its distribution is being changed, so that it is clearly identified and, after consultation with medical schools, it goes to hospitals which support undergraduate teaching and research, taking prescribed factors into account;

    b. SIFT will probably be paid under some form of "contract" which means a quantity of support may have to be defined, and further work is being done on this issue;

    c. patient care is to be provided by directly managed units and NHS Trusts and is to be purchased by health authorities (and GPs), but the way in which SIFT influences prices has yet to be decided;

    d. some teaching hospitals are likely to become NHS Trusts and as such they will be free to organise their services with the minimum of outside interference, so they will probably want to review the medical school interface;

    e. job plans will be introduced for NHS consultants (and honorary contract holders) and will make clear the individual's commitment to teaching, training and research.

13. All organisational arrangements will be put under increased strain; where management of the interface relies solely on informally apportioned resources, there may need to be change in the new environment. Such organisation will need to establish mechanisms to ensure there is no adverse effect of teaching.

14. Pressure to change existing organisational arrangements is likely to come earliest to those places where a teaching hospital applies for NHS Trust status. Systems with executive powers as in the integrated or pooled resources forms of organisation are more likely to withstand the inevitably changed circumstances. In some places existing informal arrangements for apportioned resources might well prove insufficiently robust for the effective management of undergraduate medical and dental education, suggesting that explicit and formally agreed divisions of resources and responsibilities will be required. Alternatively, a change of organisational arrangements towards either integration or pooling of resources and responsibilities may be preferred in future.

INTERIM REPORT RECOMMENDATIONS

In our first report published in June 1989 we recommended that:

a. A common database of information concerning undergraduate medical and dental education should be established as part of the future work on information for management planning.

b. The following principles are fundamental to medical and dental education:

   i. medical and dental students must be educated both in terms of promotion of good health and treatment of illness to meet the future needs of health services and to maintain the standards of their professions, as represented by the guidance and by the standards of the GMC and the GDC;

   ii. medical and dental education as part of the programmes of universities and the Health Service must be provided efficiently and in a cost effective way taking into account the available resources; and

   iii. the partnership between medical and dental schools and health authorities requires reciprocity in their dealings and planning with an appreciation of the other's needs.

c. Departmental policies for medical and dental education should be coordinated, and that published guidance relevant to medical and dental education should be consistent with these policies.

d. Medical and dental schools should have devolved budgets.

e. All new initiatives with financial implications for both sides should be costed and an apportionment agreed.

f. The Dean, or equivalent officer responsible for medicine and dentistry should be a member of the Universities Planning and Resources Committee and that this committee should take cognisance of the views of Health Service Managers.

g. There should be a "common agenda" for planning which embraces the need for those involved to share information and views on:-

   i. existing services and plans;

   ii. current issues and progress;

   iii. future prospects.

h. As part of their planning processes, providers of undergraduate medical and dental education should issue joint planning statements of their aims and objectives for medical and dental education, and reports on performance and achievements.

i. The future remit and membership of Regional University Liaison Committees should be determined in the context of "Working for Patients".

j. The scope for reconciling the interests of undergraduate medical and dental education with those of charities who fund staff should be investigated further.

k. Providers of health care should be consulted on the nature and special interest of academic appointments and health authorities should be represented in the process of making academic appointments. (Medical and dental schools have the right to participate in the appointment of NHS consultants in teaching hospitals.)

l. i. current data collection and assembly procedures be amended to meet the special demands of planning medical and dental education;

ii. new information should be collected where "gaps" currently exist - notably in the areas of sources of funding, staff teaching load, and students' courses and deployment across hospitals;

iii. key summary statistics should be published annually by each medical and dental school as should comparable national statistics by Government;

iv. a standing working group should be set up to maintain and monitor the information systems.

m. We should be commissioned to go on to consider postgraduate education and research, insofar as they are linked to, and affect, undergraduate education.

n. We undertake further work to explore the implications of an increase in primary and community care as part of the changing pattern of medical service.